Chapter Six: Shifting Perspectives and Future Actions

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In the ongoing battle against stigma associated with substance use disorders and mental illnesses, evolving perspectives and innovative approaches play pivotal roles. This chapter delves into the intricate dynamics of how perceptions and language shape stigma, the challenges inherent in evaluating stigma reduction initiatives, and actionable recommendations for the future. By examining debates such as the brain disease model of addiction, the functional roles of stigma in society, and the importance of person-centred language, this chapter provides a comprehensive analysis of current efforts and future directions. Ultimately, it seeks to offer a roadmap for stakeholders aiming to create a more inclusive and supportive environment for individuals affected by SUD and mental illnesses.

1. Functionality and Stigma

Addressing stigma requires attention to be paid to its functional roles in society. Phelan et al. (2008) argue that the stigma associated with both SUDs and mental illnesses, whether rooted in exploitation/domination dynamics or norm enforcement, necessitates structural changes in power relations and social norms. Efforts to eradicate stigma must therefore go beyond individual attitudes to include systemic reforms that address inequalities and promote inclusive policies across healthcare, criminal justice, and social service sectors. Understanding the functional roles of stigma can guide the development of comprehensive strategies that address its root causes and manifestations.

2. Language and Communication Challenges

Language norms are continuously evolving, and consensus on preferred terms among patient groups is not always achieved. However, researchers, clinicians, and others who engage with or discuss mental and substance use disorders are encouraged to use neutral, person-centred language to avoid potential stigmatisation. This approach emphasises that a disorder or illness is only one aspect of a person's life, rather than the defining characteristic. For example, it is recommended to describe someone as 'a person with schizophrenia' or 'a person with psychosis' rather than 'schizophrenic' or 'psychotic'. Similarly, rather than labelling someone with drug addiction as an 'addict' or 'abuser', they should be described as having a substance use disorder or an addiction. Likewise, someone should be referred to as 'a person with an alcohol use disorder' rather than 'an alcoholic'. The term 'alcoholic' should not be used as an adjective, either; for instance, 'alcohol-associated liver disease' is preferred over 'alcoholic liver disease' to reduce the potential stigma affecting people needing care for liver disease, including those requiring liver transplants.

Additionally, it is crucial to avoid terminology that implies a negative value judgment. For instance, when discussing suicide, it is more appropriate to say 'died by suicide' instead of 'committed suicide', as 'commit' connotes criminality or sin. Suicide attempts should be described as 'survived a suicide attempt', similar to how one might describe someone who has survived cancer or a heart attack. In substance use contexts, terms like 'clean' and 'dirty' should be avoided when referring to drug toxicology results (i.e. negative or positive urine tests), and 'clean' should not be used to describe someone who is abstinent from drugs or in recovery from a drug use disorder. Importantly, the word 'abuse', both as a noun and a verb, should be replaced by 'misuse' or 'use'. Although 'abuse' was once a diagnostic category and still appears in some surveys, its removal from the DSM-5 in 2013 marked a significant shift towards conceptualising addiction as a treatable medical condition rather than a form of misbehaviour. Despite this, the term 'abuse' remains in the names of some National Institutes of Health (NIH) Institutes studying addiction, though there is growing interest in changing these names to reflect current understandings of addiction as a disorder (Volkow et al. 2021).

The significance of language lies in its power to reflect and reinforce attitudes and behaviours. The Lancet Commission advocates for person-first language, such as 'a person with a mental health condition', over identity-first language. However, the choice of terms should ultimately rest with those directly affected. Additionally, certain terms may be stigmatising in specific languages. For instance, in Arabic, the term *soha aklia*, meaning 'mental health', can be stigmatising as it hints at impaired mental capacities. In contrast, *soha nafsia*, meaning ‘psychological health’, is preferable because it avoids these negative implications (Thornicroft et al. 2022).

Some phrases can victimise, criminalise, or misrepresent individuals with mental health conditions, such as ‘commit suicide’. Terms like ‘mental illness’ or ‘mental disorder’ can carry negative connotations, although they are used in the ICD and DSM. Despite some people viewing these diagnostic terms as devaluing labels, diagnoses are necessary for communication among health workers, individuals with lived experiences, family members, and policymakers, as well as for planning and financing treatments and care.

Effective communication strategies are essential for reducing stigma. Strategies that use personal narratives to engage audiences and highlight structural barriers to treatment are particularly promising. Current research suggests these strategies can increase public support for policies benefiting people with mental illness or substance use disorders without increasing stigma. However, communication strategies that link mental illness with violence can increase individuals’ willingness to pay taxes to improve the public mental health system, but they also elevate stigma. Messages focused on barriers to treatment offer a compelling alternative to stigmatising, violence-focused messaging for advocates and policymakers interested in promoting policies to strengthen the treatment system (McGinty et al. 2018).

Considering the high burden of substance use disorders around the world, particularly the ongoing opioid epidemic, it is critical to develop new communication strategies that can increase public support for evidence-based public health and medical policies to prevent and treat the morbidity and mortality associated with substance use disorders. Communication efforts should focus on specific policies with proven benefits, such as harm reduction initiatives, safe consumption sites, syringe exchange programmes, and increasing access to medication-assisted treatment for substance use disorder.

3. Challenges in Evaluating Stigma Reduction Initiatives

Evaluating the effectiveness of large-scale stigma reduction initiatives presents significant methodological challenges. Studies often rely on non-randomised designs, self-reported data susceptible to social desirability biases, and inadequate differentiation of attitudes towards different behavioural health disorders. Moreover, longitudinal assessments are hindered by the lack of baseline data and standardised outcome measures that capture nuanced changes in stigma perception over time. Comprehensive evaluations must address these limitations by employing robust methodologies that measure behavioural outcomes, financial costs, unintended consequences, and long-term sustainability across diverse populations and intervention settings (National Academies of Sciences, Engineering, and Medicine 2016).

Specific challenges in assessing the impact of large-scale stigma reduction initiatives include discrepancies in survey methodologies, limited data granularity that obscures community-level impacts, and inadequate representation of minority experiences. These initiatives often face barriers in measuring structural changes resulting from policy interventions and fail to adequately capture differential impacts on marginalised groups. Overcoming these challenges requires collaborative efforts to improve data collection, enhance methodological rigor, and prioritise equity in evaluating stigma reduction efforts across diverse sociocultural contexts (National Academies of Sciences, Engineering, and Medicine 2016).

4. Changing Perspectives

The previous discussion on language and communication challenges illustrates the importance of how we talk about mental illness and substance use disorders. This ties into broader debates about the conceptualisation of these conditions. One such debate is the framing of SUD as a 'brain disease' to combat stigma. Proponents argue that emphasising the biological underpinnings of addiction can shift perceptions away from viewing it as a moral failing (Hall et al. 2015). This aligns with the importance of person-centred language, aiming to reduce stigma by focusing on the medical aspects of the condition.

However, critics like Dr Joan Trujols (2015) challenge this perspective, asserting that the brain disease model of addiction (BDMA) may inadvertently reinforce stigma by overshadowing the socio-environmental factors influencing addiction. This critique emphasises the need to consider the broader context of an individual's life, much like the argument for using language that reflects that a disorder or illness is only one aspect of a person's identity.

Hall et al. (2015) acknowledge the limited empirical support for BDMA's stigma-reducing effects and highlight potential unintended consequences on self-efficacy and perceived control among individuals with SUD. This underscores the complexity of stigma reduction strategies and the necessity for evidence-based approaches that integrate both medical and psychosocial dimensions of addiction and mental illness.

By examining these perspectives, we can see that both language and conceptual frameworks play critical roles in shaping public attitudes and policies. This holistic view reinforces the need for nuanced communication strategies that consider all facets of an individual's experience with mental health conditions and substance use disorders.

5. Recommendations for Future Action

To advance stigma reduction efforts in substance use disorders and mental illnesses, several key recommendations emerge:

a. Research and evidence: invest in longitudinal studies that examine the long-term impacts of stigma reduction strategies on behavioural outcomes and quality of life among individuals with SUD and mental illnesses.
b. Policy and advocacy: advocate for policy reforms that integrate stigma reduction into healthcare policies, promote anti-discrimination laws, and support equitable access to evidence-based treatment.
c. Community engagement: foster partnerships between healthcare providers, advocacy groups, and community stakeholders to develop culturally sensitive stigma reduction interventions.
d. Education and training: provide training programmes for healthcare professionals and educators on stigma reduction, emphasising the use of person-centred language and empathetic communication in clinical practice and public outreach.
e. Evaluation and accountability: implement comprehensive evaluation frameworks that measure the effectiveness, cost-effectiveness, and sustainability of stigma reduction initiatives, ensuring accountability and continuous improvement.

By addressing these recommendations, stakeholders can collaborate effectively to create a more inclusive and supportive environment for individuals affected by substance use disorders and mental illnesses, ultimately reducing stigma and improving outcomes across global communities.

6. Conclusion

As we navigate the complex landscape of stigma reduction in substance use disorders and mental illnesses, it is clear that multifaceted strategies are essential for meaningful progress. This chapter has explored the nuanced debates surrounding the brain disease model of addiction, highlighted the critical role of language in shaping perceptions, and addressed the significant challenges in evaluating large-scale stigma reduction initiatives. The recommendations for future action emphasise the importance of research, policy advocacy, community engagement, education, and rigorous evaluation. By embracing these strategies, stakeholders can foster a more empathetic, evidence-based, and equitable approach to addressing stigma, ultimately improving outcomes and quality of life for those affected by SUD and mental illnesses. The path forward requires collaborative effort and sustained commitment to dismantling the barriers of stigma and promoting a culture of understanding and support.

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